Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVIORAL HEALTH
5555 FREDERICKSBURG ROAD 102
SAN ANTONIO TX 78229

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-4911-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These claims were for a functional restoration program, which was preauthorized and found to be 'medically necessary'. The program was certified on 4/20/11…Claims were submitted with the original HICF 1500 form, group notes and physical therapy notes for these dates of service which supported the 8 hour daily program."

Amount in Dispute: $2890.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2011 May 5, 2011	Chronic Pain Management – CPT code 97799-CP (8 hours billed)	$680.00/day X 2 = $1360.00	$1360.00
May 11, 2011 May 12, 2011	Chronic Pain Management – CPT code 97799-CP (9 hours billed)	$765.00/day X 2 = $1530.00	$1400.00
TOTAL		$2890.00	$2760.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, titled *Preauthorization, Concurrent Review, and Voluntary Certification of Health Care* effective May 2, 2006, 31 TexReg 3566, requires preauthorization for chronic pain management programs.
4. Texas Labor Code 413.014, effective September 1, 2005, prohibits the insurance carrier from raising the issue of medical necessity on preauthorized treatment.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 12, 2011
   - W4-No additional reimbursement allowed after review of appeal/reconsideration. $0.00
   - 850-664-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the requestor submit this dispute in the form and manner required by 28 Texas Administrative Code §133.307?
2. Does a preauthorization issue exist?
3. Did the submitted documentation support the number of hours billed?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(B), requires that the request shall include "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not a copy of the EOB detailing the insurance carrier's response to the original submission. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).

2. Because the original EOB was not submitted to determine the insurance carrier's denial, the Division will review the disputed services based upon applicable Division rules and fee guidelines.

   The requestor states in the position summary that "These claims were for a functional restoration program, which was preauthorized and found to be 'medically necessary'. The program was certified on 4/20/11."

   On July 26, 2011, the requestor wrote to the respondent that "These particular dates of service were denied per '876 SERVICE DISALLOWED PER PEER REVIEW."

   28 Texas Administrative Code §134.600(p) Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

   On April 20, 2011, the Division finds that the respondent gave preauthorization approval for an "Additional FRP 5 days weeks x 2 weeks". The requestor did not submit the original preauthorization report, but the April 20, 2011 report noted that 20 number of visits had been authorized. Therefore, the Division finds that a preauthorization issue does not exist.

   Texas Labor Code 413.014(e) states "If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service." Therefore, the requestor's letter to respondent's reference the denial of reimbursement based upon "876 SERVICE DISALLOWED PER PEER REVIEW" is not in accordance with Texas Labor Code 413.014(e).

3. Because the original EOB was not submitted to determine the insurance carrier's denial, the Division will review the disputed services based upon applicable Division rules and fee guidelines.

   The requestor wrote that "Claims were submitted with the original HICF 1500 form, group notes and physical therapy notes for these dates of service which supported the 8 hour daily program."

The requestor submitted the following documentation to support billed services:

DATE	DOCUMENTATION	SIGNATURE	NO. OF HRS DOCUMENTED	NO. OF HRS PAID
April 29, 2011	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (11-12)	Andrea Zuflacht, M.S., LPC Cecilia Solis, BA	3	0
	Functional Restoration Daily Treatment Record (Documented 5 hrs) Time In 8:00/Time Out 4:00	Dr. Betltran	5	0
May 5, 2011	Daily Group Progress Note (8-9) Daily Group Progress Note (9-10) Daily Group Progress Note (10-11)	Andrea Zuflacht, M.S., LPC	3	0
	Functional Restoration Daily Treatment Record (Documented 5 hrs) Time In 8:00/Time Out 4:00	Dr. Felman	5	0
May 11, 2011	Daily Group Progress Note (8-9) Daily Group Progress Note (9-10) Daily Group Progress Note (10-11)	Andrea Zuflacht, M.S., LPC Cecilia Solis, BA	3	0
	Functional Restoration Daily Treatment Record (Documented 5 hrs) Time In 8:00/Time Out 5:00	Dr. Felman	5	0
	Occupational 1 hr	Andrea Zuflacht, M.S., LPC	1	0
May 12, 2011	Daily Group Progress Note (8-9) Daily Group Progress Note (9-10) Daily Group Progress Note (10-11)	Andrea Zuflacht, M.S., LPC Cecilia Solis, BA	3	0
	Functional Restoration Daily Treatment Record (Documented 5 hrs) Time In 8:00/Time Out 5:00	Dr. Felman	5	0
	Pain Management	Andrea Zuflacht, M.S., LPC	1	0
TOTAL			34	0

Per the ODG, "Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed)."

The Division finds that the requestor's documentation did not explain why the treatment duration exceeded the eight hour sessions; therefore, the billing of nine hours on May 11, 2011 and May 12, 2011 is not in accordance with the ODG. Therefore, only eight hours of treatment per day will be considered for reimbursement.

In addition, the Division finds that the requestor's billing did not take into consideration lunch or breaks in the

number of hours billed; therefore, a one hour reduction will be taken per day. The requestor is due reimbursement of seven (7) hours per day.

4. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

For dates of service, April 29, 2011 and May 11, 2011, the Division finds that the requestor is due reimbursement for fourteen (14) hours of treatment. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the fourteen hours is $1400.00. The respondent paid $0.00. The difference between the MAR and amount paid is $1400.00. The requestor is seeking $1360.00 for these dates; this amount is recommended for reimbursement.

For dates of service, May 11, 2011 and May 12, 2011, the Division finds that the requestor is due reimbursement for fourteen (14) hours of treatment. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the fourteen hours is $1400.00. The respondent paid $0.00. The difference between the MAR and amount paid is $1400.00; this amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $2760.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2760.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		4/25/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.